DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC accepted 11/19/07 [illegible]

PRINTED: 11/05/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295079	A. BUILDING _____ B. WING _____	10/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN MOUNTAINVIEW HEALTH	201 KOONTZ LANE CARSON CITY, NV 89701

DISCLAIMER CLAUSE
PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S [illegible] THE FACTS ALLEGED AND CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLEY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification survey conducted at your facility on 10/15/07 through 10/19/07. The census at the time of the survey was 126. The sample size was 27. Four complaints were investigated during the survey. Complaint #NV00015915 was a facility reported incident regarding a fall with significant injury. The complaint was substantiated with deficiencies. See F225. Complaint #NV00015933 alleged that a resident was not provided incontinence care in a timely fashion. The complaint was unsubstantiated with other regulatory deficiencies identified. (See F157, F278, and F324) Complaint # NV00015974 was a self reported incident regarding a resident fall with injuries. The event was substantiated. No deficiencies were cited. Complaint #NV00015839 was a self reported incident regarding resident fall with significant injury. The event was substantiated. No deficiencies were cited. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	F 000	**F 157** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident #21 has been discharged from the facility. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** Admission Director and/or designee will obtain responsible party(s) phone number on admit and have Medical Records and/or designee transcribe it onto the face sheet. Phone numbers on face sheets will be verified at Care Conference meeting.	11/30/07 11/30/07 11/30/07
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] Administrator	Administrator	11/14/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
NOV 14 2007
BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY NEVADA

POC accepted 11/9/07 [illegible]

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F 157	Continued From page 1 A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to notify the responsible party of a significant change in condition for 1 of 27 residents. (#21)	F 157	**How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change.** Social Services and/or designee will monitor any changes and inform Medical Records of any changes, and receive updated copy of face sheet. Any findings will be presented at quarterly QA meeting for additional performance improvement.	11/30/07

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F 157	Continued From page 2 Findings include: Resident #21: The resident was admitted to the facility on 7/19/07 with diagnoses including heart dysfunction post cardiac surgery, debility, cerebrovascular anomaly, blindness, and chronic pain. The resident was undergoing extensive rehabilitation from physical therapy, occupational therapy, and speech therapy. The resident was to be discharged home on 8/20/07. On 8/18/07 the resident was found face down on the floor of her room with broken front teeth and bleeding from the nose. The resident was transported to the hospital for evaluation. According to interdisciplinary progress notes of 8/18/07 at 6:35 PM, the nurse attempted to call the spouse from the phone numbers listed on the face sheet. The numbers were incorrect as verified by the spouse and son on 8/19/07. No further attempts to contact the family were documented. The resident's spouse and son came to visit the resident on 8/19/07 about noon and discovered that the resident had been admitted to the hospital. A review of the transfer sheet from where the resident came on 7/19/07 revealed that the phone number listed was correct. The phone number had been transcribed incorrectly on the facility face sheet. A review of the local telephone book in the facility revealed that the spouse's correct phone number was listed.	F 157	**F 278** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident #21 has been discharged from the facility. Resident #11 is deceased. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** Director of Nursing to in-service MDS Nurses on MDS accuracy. In-service completed on November 12, 2007. Director of Nursing to supply list of falls to MDS Nurses.	11/30/07 11/30/07 11/30/07
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278		

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F 278	Continued From page 3 each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for 2 of 27 residents. (#11 and #21) Findings include: Resident #11: The resident was admitted to the facility on 6/29/07 with diagnoses including Alzheimer's dementia with behaviors, and hypertension. The admission MDS dated 7/13/07 did not reveal any skin problems. According to	F 278	**How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change.** Director of Nursing to do random MDS review for accuracy monthly then quarterly thereafter to ensure deficiency is corrected and report findings to QA committee quarterly.	11/30/07

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F 278	Continued From page 4 the medical record the resident developed a Stage II pressure sore on the coccyx on 7/19/07. A review of the MDS dated 8/2/07 revealed no indication of skin problems on the assessment. Resident #21: The resident was admitted to the facility on 7/19/07 with diagnoses including heart dysfunction post cardiac surgery, debility, cerebrovascular anomaly, blindness, and chronic pain. The resident was undergoing extensive rehabilitation from physical therapy, occupational therapy, and speech therapy. The resident was to be discharged home on 8/20/07. According to the interdisciplinary (IDT) progress notes of 7/20/07 the resident was found on the bathroom floor having slipped during self-toileting. A review of the admission MDS completed on 7/25/07 did not indicate any falls within the last 30 days. Cross reference Tag F 323, Accidents and Supervision	F 278	**F 280** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** A care conference invitation has been developed to include name of the person to be invited, resident and/or responsible party. A care conference has been scheduled for resident #3. Resident #3 has been invited to attend the care conference.	11/30/07
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280	**How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice.	11/30/07

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F 280	Continued From page 5 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure the participation of competent residents in the planning of care and treatment for 1 of 27 residents. (#3) Findings include: Resident #3: The resident was admitted on 11/09/06 with diagnoses including uncontrolled diabetes, abnormal gait, depression, heart disease, circulation problems, high blood pressure, high blood lipids, macular degeneration, thyroid problems, and constipation. There was no diagnosis of dementia nor was he conserved. On 10/15/07 at 1:30 PM, in interview, Resident #3 stated that he had never been invited or notified of his right to participate in the planning of his care at the initial, or any of the quarterly care conferences held since his admission. On 10/17/07, review of the record for Resident #3 found no evidence of notice (or invitation to the resident), about the initial or quarterly care conferences held by the facility to plan his care. On 10/18/07 in interview, this information was	F 280	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** IDT will be in-serviced on inviting residents to Care Conference Meetings and was completed on November 9, 2007. Name of person invited to the Care Conference Meeting will be written on the letter and documented on resident's record by Social Services and/or designee. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change.** Social Services and/or designee will monitor for compliance and present any findings at the quarterly QA meeting.	11/30/07 11/30/07

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F 280	Continued From page 6 verified with Social Worker #1 and Social Worker #2 who stated that it was an oversight.	F 280		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and policy review it was determined that the facility failed to ensure that licensed staff administered medications in accordance with facility policy and professional standards of practice for numerous residents on Stations I and II and for 1 of 27 residents. (#27) Findings include: The facility policy identified as "Administration of Drugs" specified that: "#2. All medications must be administered exactly as prescribed in written orders of the attending physician." "#8. Medications must be administered within one hour before or after the time specified on the medication administration record (MAR), except those ordered before or after meals. Such orders must be administered one half hour before or after ingestion of food." "#12. If a dose of regularly scheduled medication is withheld, refused or given at other than the scheduled time..., initial and circle initials on the front of the MAR in the space provided for that dosage administration." "#13. Enter an explanatory note on the reverse side of the record in the space provided for as needed (PRN) documentation. If three	F 281	**F 281** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident #27 – There was no negative outcome on this resident. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice.	11/30/07 11/30/07

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F 281	Continued From page 7 consecutive doses of a medication are withheld or refused, notify the physician." During the initial tour of Station I on 10/15/07, licensed practical nurse (LPN) #5 stated that she was passing 8:00 AM medications at 9:30 AM. On 10/16/07, LPN #6 was observed to finish passing the medications scheduled for 8:00 AM at 10:10 AM. LPN #5 was interviewed at 11:00 AM and confirmed that she was still passing 8:00 AM medications. She stated that she had seven more residents that needed to have their 8:00 AM medications. LPN #5 stated that she was delayed because several residents had requested pain medications. She also stated that she had a lot of other interruptions as well as residents not being in their rooms or easily accessible (activity programs) that delayed medication administration. At 9:15 AM on 10/17/07, LPN #5 stated that she was still passing 8:00 AM medications for her residents on Station I; she identified 13 residents that still needed their 8:00 AM medications. The Director of Nursing (DON) was interviewed on 10/17/07 and 10/18/07. She stated that the facility was aware that medication pass was prolonged because of all the "daily only" medications that were administered at 8:00 AM. The prolonged medication pass difficulties had been reported to her. The DON stated that the medication nurses could access help by asking administrative nurses such as the staff development nurse, the two Minimum Data Set (MDS) nurses or the DON herself. On 10/18/07, RN #1 was interviewed at 10:00	F 281	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** Director of Nursing and/or designee, will provide in-service to licensed nurses in regards to Policy and Procedure on Medication administration, (medication time administration, observance of resident to completely take medication, check tube placement prior to each feeding/flush, sign the MAR after medication administrated to resident, document of any refusal of medication). In-service completed on November 13, 2007. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change.** Director of Nursing and/or designee to do random med pass observation and review documentation on the MAR monthly then quarterly thereafter to ensure deficiency is corrected and report any findings to QA Committee quarterly.	11/30/07 11/30/07

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F 281	Continued From page 8 AM. She confirmed that she was still passing 8:00 AM medications and had four residents remaining. She stated that morning medications did take a long time and that there was no other staff to ask to assist if the medication pass was delayed. RN #1 acknowledged that it was the responsibility of the medication nurse to complete the medication pass. She was observed at 10:30 AM, still passing medications. On 10/18/07, LPN #5 stated that medication pass in the morning always took a long time because of all the medications that had to be administered. LPN #5 stated that there were no staff that could be used to assist with the 8:00 AM medication pass. She stated that medications scheduled at 8:00 AM that were ordered three times a day or four times a day and were given after 11:00 AM on 10/16/07, did not have their times adjusted to allow a therapeutic drug level maintained for the rest of the day. (Medications that were ordered three times a day were scheduled at 8:00 AM, 2:00 PM, and 8:00 PM and medications that were ordered four times a day were scheduled at 8:00 AM, 12:00, 4:00 PM and 8:00 PM.) The Medication Administration Records (MAR) were reviewed for Station I and failed to reveal evidence of documentation that the medications were given outside of the two hour window as indicated in the facility policy. The facility's policy and procedure "Administering of Drugs" was reviewed. Procedure 9d read, "Administer all medications, observing the resident to be sure of complete and safe ingestion." On 10/16/07, a medication pass observation was	F 281		

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F 281	Continued From page 9 done on Station II. RN #1 was observed to pour the contents two capsules of a medication into a bowl of oatmeal. She took the bowl of oatmeal and left it in front of a resident seated in the Station II dining room. She then left the dining room to continue passing medications to other residents. RN #1 stated in interview that the medication was Depakote sprinkles, and that the resident did not like to take medicine so they put it in his food. She stated that the certified nursing assistants would tell her if the resident did not eat his oatmeal. Resident #27: The resident was readmitted to the facility on 5/4/07 with a gastrostomy tube (G-tube) in place for the administration of nutrition, hydration and medications. On 10/16/07 at 7:20 AM, LPN #8 was observed to administer Resident #27's medications via the G-tube. LPN #8 stopped the pump providing the enteral nutrition and administered the following medications into the G-Tube: crushed Aspirin 81 mg, crushed Metoprolol 50 mg, crushed Calcium with Vitamin D, Dilantin liquid 100 mg, crushed multivitamin, Reglan liquid 5 mg, and liquid iron 325 mg. The nurse was not observed to check for tube placement or residual contents by aspiration or auscultation. On 10/16/07 record review for Resident #27 revealed a physician's order dated 5/4/06 that read: "Check tube placement prior to each feeding or flush (aspiration or auscultation). On 10/19/07 review of the facility policy regarding administration of medications via G-tube revealed that 30 cc of air was to be injected into the G-tube	F 281		

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F 281	Continued From page 10 with a 60 cc syringe while listening with a stethoscope for a swish sound over the stomach to confirm correct placement prior to administration of medications or fluid flush. Review of the facility Policy and Procedure for administering drugs revealed in Procedure #9 "The proper procedure for administering medications is: a. Identify and prepare all medications to be administered to a single resident, b. Bring all medications and a suitable liquid to aid in swallowing to the resident, c. Make positive identification of the resident, d. Administer all medications, observing the resident to be sure of complete and safe ingestion, e. Document the administration of all medications, f. Return to the MAR and document any problems with administration (i.e.: dropped doses, refused doses, etc.)." On 10/17/07, an observation was done in Station II. LPN #4 was observed signing the MAR prior to administering medications to the resident. In interview, LPN #4 stated it was policy to document on the medication records prior to administering medications. On 10/17/07, the DON was interviewed and stated it was the policy to document medications after administering to the resident.	F 281	**F 323** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident #21 has been discharged from the facility. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.**	11/30/07 11/30/07 11/30/07
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	IDT will review Incident Report(s) and make recommendation(s) if it is appropriate and update care plan preventative measures according to resident(s) need(s). Director of Nursing and/or designee to in-service IDT in regards to appropriate preventative measures. In-service completed on November 9, 2007.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to initiate preventive measures on the initial assessment to prevent an accident for 1 of 27 residents. (#21) Findings include: Resident #21: The resident was admitted to the facility on 7/19/07 with diagnoses including heart dysfunction post cardiac surgery, debility, cerebrovascular anomaly, blindness, and chronic pain. The resident was undergoing extensive rehabilitation from physical therapy, occupational therapy, and speech therapy. The resident was to be discharged home on 8/20/07. On 7/19/07 Resident #21 was found on the bathroom floor. The resident was alert and oriented and indicated she slipped while self-toileting. A nursing reassessment was initiated and the nurse checked the box indicating the need for a Tabs alarm in bed. The care plan dated 7/20/07 indicated a Tabs alarm while in the the wheelchair. According to LPN #1, Resident #21 was not using a wheelchair except during the very beginning of her stay; she ambulated using a walker most of the time. LPN #1 indicated the resident was very independent and was non-compliant with asking for assistance. There was no documentation of a Tabs alarm in bed. On 8/6/07 Resident #21 underwent an outpatient procedure of radiofrequency ablation of the lateral branch bilaterally of S1-S2. In the	F 323	**How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change.** Director of Nursing and/or designee will do random chart review on preventative measures and resident observation on a monthly basis to ensure compliance and report any findings to QA Committee on a quarterly basis.	11/30/07

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F 323	Continued From page 12 Interdisciplinary Team (IDT) progress notes of 8/7/07, physical therapy indicated the resident experienced an increase in right sided weakness and difficulty following instructions. Physical therapy notified nursing. The nurse sent a fax to the attending physician on 8/7/07 about the change in condition. There was no documentation of an evaluation of the resident's symptoms or treatment by the facility or physician orders. The next progress note was written 8/9/07 and indicated that the short term right sided weakness was resolved now. On 8/18/07 Resident #21 was found face down on the floor of her room with broken front teeth and bleeding from the nose. The resident was transported to the hospital for evaluation. An interview with the RN#1, revealed that the resident did not have a Tabs alarm on her bed at the time of the fall.	F 323	**F 325** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident #14 has been assessed by the Registered Dietitian and care plan has been updated to reflect interventions until weight loss issue is resolved. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice.	11/30/07 11/30/07
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to assess, monitor, and prevent significant weight loss for 1 of 27 residents. (#14) Findings include:	F 325		

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F 325	Continued From page 13 The facility's policy and procedure for Weights was reviewed. Under weekly weights, the following is documented, "The following are guidelines for residents who may need to be weighed weekly (not all inclusive):...significant weight loss/gain 5% 30 days, 7.5% 90 days, 10% 180 days." Under re-weigh, the following is documented, "Any weight with a 5-lb variance is re-weighed within 24 hours...If variance is actual after re-weigh, the nurse documents in the medical record, revises the care plan, refers to Nutritional/Hydration/Skin Committee and notifies the physician and resident/resident's authorized representative. This notification is recorded on the Weight Record in the appropriate column. When the Nutrition/Hydration/Skin Committee or designee reviews the weights, the committee determines which residents are evaluated and/or requests a re-weigh. The team or designee reviews the resident's status and makes recommendations." The facility's policy and procedure for Nutrition Monitoring Protocol was reviewed. Procedure 1 was documented as "Resident's with identified nutrition risk factors are evaluated by the IDT (interdisciplinary team). A. Nutrition factors to consider:... 2. Significant weight loss or weight gain, reweigh of greater than 5 lb. variance....B. As indicated, initiate the following: 1. Individualized care plan interventions. 2. Referral to Nutritional/Hydration/Skin Committee. 3. Resident/resident's authorized representative notification. 4. Documentation of the above in the medical record." Resident #14: The resident was admitted to the facility on 4/29/03 with the following diagnoses:	F 325	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** Director of Nursing and/or designee will review weight record. Resident with significant weight loss will be reviewed at Nutritional Committee and refer to Registered Dietitian. Any recommendation(s) made by Registered Dietitian and Nutritional Committee will be reviewed by Director of Nursing and/or designee. Director of Nursing and/or designee to in-service Nutritional Committee in regards to assessment, weight monitoring and significant weight loss prevention. In-service completed on November 13, 2007. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change.** Registered Dietitian, Director of Nursing and/or designee will do monthly weight review to ensure compliance and report any findings to the QA Committee on a quarterly basis.	11/30/07 11/30/07

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F 325	Continued From page 14 vascular dementia with delusion, hypertension, hypothyroidism, esophageal reflux, hearing loss, osteoarthrosis, and debility. Review of Resident #14's medical record revealed the resident's recorded weights from 5/3/05 to 12/11/06 ranged from 148 to 158 pounds. Beginning on 1/3/07 her weights were documented monthly as follows: 1/3/07: 159 2/6/07: 160 3/6/07: 158 4/3/07: 157 5/5/07: 158 6/6/07: 150 Comments down 8 lbs (pounds) 7/4/07: 134.6 7/4/07: Reweigh 134.6 8/5/07: 134 9/1/07: 137 10/7/07: 135 Review of the annual nutrition evaluation, dated 1/9/07, revealed Resident #14's height to be 62 inches, with an ideal body weight of 110 pounds. Review of the nutritional note entry by the dietician on 6/18/07 revealed, "6/6/07, 150#s, down from 158# 5/5/07 and a 5.06% weight loss in a month. 5/18 NRS (nursing) notified physical resident has had increased crying. Had some psych (psychiatric) med (medication) changes. Atenolol dosage halved 3/15/07. Resident has had increased confusion and exit the last 6 months requiring her to be transferred to a locked unit....Resident still obese at 150 and nursing agrees she is better at this weight and weight loss beneficial at this stage and put on weekly weights. On 7/17/07 the following entry was documented, "7/4/07 weight 135, down from 150# 6/6/07, a 10% weight loss/month....7/6/07 Alb (albumin) 2.8	F 325		

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F 325	Continued From page 15 (down), 4/6/07 Alb 3.4, 1/6/07 3.2. She has had some psych med changes and is verbally abusive at times. She was on Resource 2 60 ccs with medication pass-recommend restart." Review of Resident #14's care plan for nutritional status revealed: "potential for weight loss r/t (related to) dementia, GERD (gastroesophageal reflux disease), therapeutic diet." An entry dated 6/18/07 documented 5.06% weight loss in one month and an entry dated 7/17/07 documented a 10% weight loss in one month. The care plan goal was "Resident will maintain current weight unless clinically unavoidable x 90 days" with a target dates 5/28/07, 7/07, 10/07, and 12/07. Review of the nutritional status care plan revealed the following standard approaches, "Dietician referral. Record food intake per facility protocol. Offer meal replacement per facility protocol. Verbal cueing as necessary and assist if indicated. Allow sufficient time for resident to feed self. Weigh resident per facility protocol." There was one hand written entry, "Honor likes/dislikes." Review of the record for Resident #14 revealed a physician's report of visit dated 7/12/07 that read, "The patient has had a fairly significant weight loss of something a little over 20 pounds in the last 2 months." A physician's telephone order on 7/12/07 read, "Dietician eval please 20 pound weight loss last 2 months with low albumin on panel." On 7/20/07, "Resource Plus (60cc's) BID (twice a day) with med pass" was ordered. On 10/17/07, a meal time observation was done on Station II. A meal tray was placed in front of Resident #14 at 12:10 PM. Resident #14 was observed to poke her fork at the meat, baked	F 325		

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F 325	Continued From page 16 potato, broccoli, and shortbread cookie. There were several small containers of sour cream, which the resident tasted, but did not eat. Resident #14 picked up the uncut broccoli with her fingers and ate 50% of the broccoli. At 12:25 PM, a certified nursing assistant (CNA) asked the resident why she was not eating. The resident stated the meat was tough. The CNA cut up the resident's meat, potato, and broccoli and offered her mashed potatoes instead of the baked potato. Resident #14 was observed to eat 25% of the mashed potatoes and six bites of the meat. On 10/17/07, the facility dietician was interviewed. She stated that the resident should have been on weekly weights since 6/6/07. Review of the restorative nursing weight records and Resident #14's medical record failed to reveal that the resident had been weighed weekly. The dietician stated that after she ordered weekly weights the order goes to the Director of Nursing and other applicable departments for review and she does not get a copy back for her records. She stated she did not know why Resident #14 had not been weighed weekly. She stated that she had not updated Resident #14's care plan as of this date, but that Resident #14 was on her list to be reviewed and updated.	F 325	**F 328** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident #1 nails have been trimmed. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.**	11/30/07 11/30/07 11/30/07
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care;	F 328	Social Services Department and/or designee will provide a list of resident(s) in need of Podiatry care and fax to Podiatrist. Podiatrist will exit with Social Services and/or designee with recommendation(s) and follow up. Any Medical follow up from Podiatrist will be referred to Director of Nursing and/or designee for follow up.	

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F 328	Continued From page 17 Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to ensure podiatry care for 1 of 27 residents. (#1) Findings include: Resident #1: The resident was admitted to the facility on 9/1/05 and readmitted on 9/18/07 after a fall with a fracture. His diagnoses in included diabetes mellitus. Review of the facility weekly skin report dated 10/10/07, revealed that he was being treated daily for a pressure ulcer on his right heel. Observations of Resident #1 in his wheelchair throughout the survey revealed that the nails of his left foot extended more that 1/2 inch beyond his 2nd, 3rd, and 4th toes. Review of the October 2007 Physician order recapitulation for Resident #1 revealed, on Page 2, an order dated 10/25/06 for a podiatry consult and treatment as indicated and on Page 3 an order dated 4/27/07 for diabetic nail care by the licensed nurse each week. On 10/18/07 at 10:45 AM, the observations and orders for Resident #1 were confirmed with the director of nurses (DON). The DON indicated that she did not want her nurses doing diabetic nail care and the procedure was for the nurse to put the resident's name on the podiatry list and that he came when there were 11 names on the	F 328	**How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change.** Director of Nursing and/or designee will do random chart review monthly and then quarterly thereafter to ensure deficiency is corrected. Findings to be reported to QA Committee on a quarterly basis.	11/30/07

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F 328	Continued From page 18 list. Review of the list used for the last podiatry visit with the DON showed that Resident #1 had been put on the list. She could not explain why he had not been seen or who was assigned to make sure that all residents on the list were seen and treated with each podiatry visit.	F 328		
F 371 SS=D	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that foods were stored and prepared under sanitary conditions during 2 of 3 kitchen observations. Findings include: During the initial tour of the kitchen at 7:45 AM on 10/15/07, a sign was observed posted on the walk-in refrigerator noting that all left-over prepared foods were to be discarded 72 hours after preparation. Inside the refrigerator, a tray cart was observed with ten prepared individual pudding-like servings. These servings were covered and all had a date of 10/10/07 (Wednesday) written on the cover. According to the posted sign these servings should have been discarded on 10/13/07 (Saturday). The dietary manager confirmed on 10/16/07, that kitchen staff were aware that all leftover foods were to be discarded after 72 hours.	F 371	**F 371** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The food was immediately discarded. The facility will store, prepare and distribute food under sanitary conditions. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** Dietary Manager and/or designee will in-service staff on the importance of infection control standards while in the kitchen.	11/30/07 11/30/07 11/30/07

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F 371	Continued From page 19 During the kitchen observation on 10/16/07, the following was observed: A food processor bowl had been replaced on it's power source. The blade and cover had also been secured. When the lid and blade were removed by kitchen staff, approximately one teaspoon of clear liquid was located under the blade at the bottom of the food processor bowl. When the bowl was removed by the kitchen staff, it was observed that there was green leafy debris between the food processor bowl and the surface of the power source. The kitchen staff confirmed that the food processor bowl had not been air-dried after cleaning or that the surface of the power source had been cleaned. During this inspection, a medical records staff member of the facility entered the kitchen and walked past the yellow line on the floor that indicated kitchen staff only. This staff member went to the coffee maker. Removing a cup from the stacked cleaned cups, she obtained a cup of coffee and then proceeded to exit the kitchen. This staff member did not have a hair net or other hair covering on. A supply of hair nets was located in the staff only bathroom located just within the entrance of the kitchen. Kitchen staff stated that this staff member did this all the time, but did not stop the staff member from entering the kitchen staff only area. The medical records staff member was interviewed before her complete exit from the kitchen and she confirmed that she knew she should not cross the yellow line in the kitchen.	F 371	**How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change.** Dietary Manager and/or designee will use CQI audit tool to make sure of compliance. Any findings will be corrected and forwarded and presented at the quarterly QA meeting for further performance improvement.	11/30/07
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		

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F 431	Continued From page 20 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that expired medications were not administered to residents, that opened vials of medication were dated when opened and that the medication	F 431	**F 431** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All expired medications were removed from the medication cart. Unsealed vials were removed from medication cart and new ones were opened and dated. Open bottle of rubbing alcohol has been removed and discarded, hand sanitizer that was expired has been discarded and enemas have been removed and stored in a different location. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice.	11/30/07 11/30/07

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F 431	Continued From page 21 refrigerator temperatures were monitored. Findings include: On 10/15/07 at 10:10 AM, observation of the 100 B medication cart revealed the following expired medications: One bottle of liquid docusate sodium 100 mg/5 ml, expired July 2007 Two 15 ml Ampules of normal saline for inhalation, expired August 2007 One bottle of docusate sodium gelcaps 100 mg, expired April 2007. On 10/15/07 at 10:20 AM, observation of the 100 A medication cart revealed the following: One 20 ml vial of Lidocaine 1% solution for injection was unsealed and undated One 1 ml vial of Haldol 5 mg/ml was unsealed and undated. On 10/15/07 at 10:30 AM, observation of the 100 Hall medication storage room found the following: One opened bottle of Rubbing Alcohol 70%, expired August 2005 One opened bottle of Antiseptic Hand sanitizer that expired July 2005 Two fleets enemas in the same cabinet as the backup stock of oral medications (vitamins, supplements etc.) On 10/15/07 at 10:45 AM, in interview, the director of nurses for the facility confirmed the above observations. She indicated that the policy was that vials should be dated when they were opened. Copies of the facility policies related to these practices were requested at this time. No copies of policies related to these practices were	F 431	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** Pharmacy Nurse Consultant and Director of Nursing and/or designee will in-service Licensed Nurses in regards to expired medication, open and dating vials, medication refrigerator temperature log. In-service completed on November 13, 2007. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change.** Pharmacy Nurse Consultant, Director of Nursing and/or designee to monitor expired medication, open date on vials and medication refrigerator temperature logs monthly then quarterly thereafter to ensure compliance and report and findings to QA Committee on a quarterly basis.	11/30/07 11/30/07

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F 431	Continued From page 22 provided to the survey team by the time of the exit conference. On 10/16/07 an observation of the Station II medication room revealed the following expired medications: Certavite with lutein, expiration date 4/07 Enteric coated aspirin, 81 mg, expiration date 6/07 Anti-diarrheal (loperamide HCL), 2 mg, expiration 6/07 Centrum chewable vitamins, expiration date 9/07 On 10/16/07, review of the Station II medication room refrigerator temperature log for the month of September 2007 revealed that the temperatures were recorded for eight out of thirty days. Review of the refrigerator temperature log for August 2007 revealed that there were eight days when the refrigerator temperature was recorded as 32 degrees. On 10/16/07, RN #1 was interviewed. She stated that it was the night nurse's responsibility to record the refrigerator temperatures. She stated that she did not know what the temperature range was supposed to be for the refrigerator or what to do if the temperature was too low. On 10/16/07, the DON and LPN #4, the staff development coordinator, were interviewed. The DON stated that it was the night nurse's responsibility to record the refrigerator temperatures. LPN #4 stated that the refrigerator temperature should be between 35 and 45 degrees Fahrenheit. The facility's policy and procedure, "Storing Drugs" was reviewed. Procedure #10 documented "Drugs requiring storage in 'A COOL	F 431		

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	295079	A. BUILDING _____ B. WING _____	10/19/2007

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F 431	Continued From page 23 PLACE' must be stored in a refrigerator designated for medications only, and maintained between 2 degrees Celsius (35 degrees Fahrenheit) and 8 degrees (45 degrees Fahrenheit). The medication refrigerator must contain a functional thermometer designed for use in a refrigerator. The refrigerator temperature should be monitored and logged on a daily basis." Procedure #12 documented, "Any outdated, contaminated, or deteriorated drugs, or those in containers which are cracked, soiled, or without secure closures must be removed from stock and destroyed according to procedures for drug destruction."	F 431		
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on policy review, record review and interview, it was demonstrated that the facility failed to ensure that tuberculosis screening of residents was adequately monitored per the facility policy. (#18, #8, and 10 random residents) Findings include:	F 441	**F 441** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident #18 has been given a 2 step PPD. Resident #8 has been given a 2 step PPD. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice.	11/30/07 11/30/07

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F 441	Continued From page 24 The facility policies regarding residents directed that all residents were to be screened for tuberculosis as part of the facility's infection control. Newly admitted residents were to have a two step tuberculosis screening initiated upon admission. Long term stay residents were to have annual tuberculosis screening. Residents who tested positive with prior tuberculosis screening tests were to have a chest x-ray. Review of the medication administration record revealed that there was a tuberculosis screening tracking method to document when the two step screening was done, and when the annual screening was to be scheduled. Resident # 18: This resident was admitted to the facility from an out of state long term care facility on 8/30/07. Her primary diagnoses were Alzheimer's disease and chronic obstructive lung disease. She was ambulatory and was independent or required minimal assistance with most activities of daily living. Review of the initial nursing assessment, facility transfer information, medication administration record (MAR) and immunization record documentation failed to reveal evidence that the resident had been screened for tuberculosis. An interview with licensed practical nurse (LPN) # 7 revealed that it was up to the individual nurses to complete the tuberculosis screening. She confirmed that there was no documentation on the immunization record or the medication administration record (MAR) that any tuberculosis screening had been done for Resident #18 since her admission. The August MAR did have indicators for step one and step two tuberculosis screening to be performed or an annual step two screening but there were no dates as to when	F 441	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** Facility will keep record of Tuberculosis screening. Medical Records to do admission audit including the Tuberculosis screening. Medical Records to provide list of residents with Tuberculosis screening monthly to Director of Nursing and/or designee. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change.** Director of Nursing and/or designee will review audit and do random chart review monthly then quarterly thereafter to ensure compliance.	11/30/07 11/30/07

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F 441	Continued From page 25 these were to be done. Staff on the admitting wing notified the out of state long term care facility on 10/18/07 to request tuberculosis screening results for Resident #18. Resident #8: This resident had resided at the facility since August, 2001 with primary diagnoses of dementia, behaviors, arthropathy. A review of the clinical record revealed that Resident #8's last annual tuberculosis screening was done in August 2006 Admissions to the facility since August 2007 were reviewed on 10/18/07 and revealed that the facility had 28 admissions in addition to Resident #18. Of those 28 residents, two were readmissions. Of those 26 residents, nine residents were no longer at the facility. Seventeen current residents immunization records were reviewed. Four residents had no documentation available in their clinical record on the units that any tuberculosis screening had been done. Two residents had had tuberculosis testing done, but not read. Two residents had had a first step performed but did not have the second step performed. Two residents were due their annual testing in August. An interview with the LPN # 4 on 10/18/07 revealed that she was the infection control and staff development nurse since May 2007. She stated that she knew her responsibilities included tracking of the staff immunization records, but had just found out one to two weeks ago that she was also responsible for resident immunization records, including flu, pneumonia and tuberculosis screening. She confirmed that the facility policy was for annual tuberculosis screening for all residents and staff. She	F 441		

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F 441	Continued From page 26 confirmed that all new residents and staff were to receive a two step screening for tuberculosis unless otherwise indicated.	F 441		